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Office of the Healthcare Advocate
STATE OF CONNECTICUT

Testimony of Victoria Veltri
State Healthcare Advocate
Before the Insurance and Real Estate Committee
Re SB 807
March 17, 2015

Good afternoon, Representative Megna, Senator Crisco, Senator Kelly, Representative Sampson, and members of the Insurance and Real Estate Committee. For the record, I am Vicki Veltri, State Healthcare Advocate with the Office Healthcare Advocate ("OHA"). OHA is an independent state agency with a three-fold mission: assuring managed care consumers have access to medically necessary healthcare; educating consumers about their rights and responsibilities under health insurance plans; and, informing you of problems consumers are facing in accessing care and proposing solutions to those problems.

Thank you for the opportunity to comment on SB 807, AAC Fairness And Efficiency In Insurance Contracting. This bill includes several components designed to improve choice, cost savings and transparency for Connecticut's health care consumers. It charges the Insurance Commissioner with the creation of a pilot program requiring health plans to offer policies with a tiered network design. These networks attribute varying cost-sharing levels depending on the plan design and the tier of the provider delivering a covered service. As cost sharing requirements in healthcare plans shift toward consumers, insured individuals will benefit from a tiered network design that combines appropriate coverage with opportunities to reduce copayments, deductibles and other out-of-pocket expenses, without imposing significant barriers to individual consumers' choice of providers.

SB 807 also improves transparency in health care pricing for consumers. Hospital mergers and provider practice acquisitions have augmented the trend of increasing utilization of hospital-based outpatient departments and hospital-owned satellite facilities. However, consumers may not always be aware of the

additional costs that can be associated with the delivery of care in these settings, in particular, the imposition of facility fees. SB 807 promotes the incorporation of site-neutral reimbursement standards into provider participation agreements with health plans. Site-neutral standards provide that reimbursements for particular services should be the same regardless of where the service is delivered, and protect consumers from unexpected and very costly fees for these services.

The Medicare Payment Advisory Commission (MedPAC) recently recommended modifying the practice concerning facility fees, promulgating a test that assesses several distinct criteria for a given service to determine if reimbursement should be site-neutral. This test assesses whether the additional quality measures inherent in a hospital setting are necessary for the safe and effective delivery of a given service – which is the reason facility fees were originally permitted. MedPAC's test considers: if the service is performed at least 50% of the time in a physician office setting, an indicator of the safety of providing the service in a non-hospital setting; whether there are minimal differences across service locations in how the service is provided; if the typical patient acuity is no different across settings; and whether the service does not have a 90-day surgical code. Services meeting these criteria are deemed to be clinically safe and appropriate to perform in a physician office setting and the additional level of care that facility fees presume to compensate for is unnecessary. MedPAC's findings identified a group of such services, listed as Group 1 of the Medicare payment classification system, and recommended the elimination of facility fee charges for these services when delivered in a hospital based setting.

The restriction against facility fees for this group of services, as amended from time to time, represents an important measure to promote effective, high quality healthcare while reducing unnecessary costs. In addition, facility fees, where they are appropriate, would be permitted for some services so long as they are based on the actual costs of providing the higher level of care that may be indicated for those services. This structure promotes equity in billing and reimbursement for the delivery of necessary treatment, while bolstering transparency in healthcare costs so that consumers can make informed and thoughtful decisions concerning where to receive their care.

The provision requiring the development of standardized health insurance forms where standardization and uniformity would be beneficial to the effective and clear delivery of healthcare. Such standardization would benefit all stakeholders engaged in our healthcare system, minimizing the administrative complexity providers must manage when working with multiple health plans, each with their own unique forms and processes. Additionally, consumers would benefit immensely from standardization in routine

plan documents, as these can vary significantly across health plans. The improvements in SB 807 promote greater transparency of health care pricing and efficiency in claims processing for consumers by establishing some uniformity in the way that both insurers and providers communicate regarding their fees, benefits and other services.

Thank you for providing me the opportunity to deliver OHA's testimony today. We look forward to continuing to collaborate and advocate for the consumers of Connecticut in this important matter. If you have any questions concerning my testimony, please feel free to contact me at victoria.veltri@ct.gov.